



**Filling out this application does not guarantee assistance**

**Housing Application**

Application Date: \_\_\_\_\_

Applicant Name: \_\_\_\_\_ Phone Number \_\_\_\_\_

Application must be mailed to:

Heather Jacobson  
90 E. Leslie Ln  
Columbia, Mo. 65202

- **COMPLETE APPLICATION COMPLETELY; ALL INCOMPLETE APPLICATIONS WILL BE PLACED ON THE BOTTOM OF THE LIST**
- Applications are reviewed for eligibility.
- If you are eligible your name will be placed in a Housing Waiting List according to the time, date, and vulnerability of your application.
- You must respond to all requests, written and via phone, made by the Phoenix Health Programs Housing Department. If you fail to respond, your name will be removed from the waiting list.
- IT IS VERY IMPORTANT TO NOTIFY THE HOUSING DEPARTMENT OF ANY CHANGES TO YOUR APPLICATION: Please report the following changes in writing:
  - Change of address
  - Change in income
  - Change in household members
- When your name reaches the top of the waiting list, the Housing Department will call, or mail letter, “offering rental or emergency assistance” to you. You must then provide verification or proof of income which you claimed on your application. You must provide a copy of each household member’s social security card and drivers license (anyone over the age of 18) immediately with your application for the waiting list.
- Rental Assistance payments to your **landlord** will not begin until **all** of your documentation is turned in. Emergency Assistance payments are paid directly to the source and will only be paid once all documentation is received.
- If all documentation is not received within thirty days of approval you will be removed from the top of the waiting list to the bottom and the process will start over again.
- More Questions??? CALL (573) 875-8880 ext 2160

Application for Housing Assistance and Emergency Assistance  
 This application will be used to determine applicant eligibility and vulnerability

**A COPY OF EACH HOUSEHOLD MEMBER'S SOCIAL SECURITY CARD AND DRIVERS LICENSE (FOR THOSE ABOVE 18 YEARS OF AGE) MUST BE ATTACHED TO APPLICATION.**

**1. APPLICANT GENERAL INFORMATION: DATE: \_\_\_\_\_ TIME: \_\_\_\_\_**

Applicant Name/Head of Household: \_\_\_\_\_

Current Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Mailing Address If Different: \_\_\_\_\_ County: \_\_\_\_\_

Home Phone Number: \_\_\_\_\_

Message Number: \_\_\_\_\_

Is it ok to leave a message: Yes or No

**2. HOUSEHOLD COMPOSITION:**

FULL NAME	RELATIONSHIP TO THE HEAD OF HOUSEHOLD	SEX M/F	BIRTHDATE	AGE
1.				
2.				
3.				
4.				
5.				

FULL NAME	RELATIONSHIP TO THE HEAD OF HOUSEHOLD	SEX M/F	BIRTHDATE	AGE
6.				
7.				
8.				
9.				

3. **HOUSEHOLD INCOME SUMMARY:** For each type of income that your household receives, list the source of income and the monthly GROSS amount (before taxes and deductions). Income sources include: Wages, social security, SSI, DDI, VA pensions, TANF, unemployment, workers compensation, child support, ect.

<u>Name of Person Receiving Income</u>	<u>Source of Income</u>	<u>Monthly Amt</u>	<u>Annual Amt</u>
<u>1.</u>			
<u>2.</u>			
<u>3.</u>			
<u>4.</u>			
<u>5.</u>			
<b>FOR OFFICE USE ONLY</b>		<b>TOTAL</b>	<b>ANNUAL</b>
		<b>GROSS INCOME</b>	
<b>FOR OFFICE USE ONLY</b>		<b>SCORE</b>	
		<b>50%</b>	<b>25%</b>

4. **ASSETS:** (Real Estate, Checking, Savings, CD's, Stocks, Bonds, ect.)

- a. Do you or any member of your household have full or partial ownership of a home or other real-estate?  Yes  No  
 If yes please explain: \_\_\_\_\_
- b. Have you or any member of your household sold or given away any real-estate property or any other assets in the past 2 years?  Yes  No  
 If yes, please explain: \_\_\_\_\_
- c. For each asset, give the source, total value, and income received from the asset in the space below. \*if you do not have any assets, insert "NO ASSETS"

<u>Family Member</u>	<u>Type of Asset</u>	<u>Cash Value</u>	<u>Annual Income from Asset</u>
<u>1.</u>			
<u>2.</u>			
<u>3.</u>			
<u>4.</u>			
<u>5.</u>			
<b>(For Office Use Only)</b>		<b>Total Cash Value</b>	

**5. Other Household Characteristics:**

- a. **Citizenship:** Are all household members citizens of the United States?  
 Yes       No
  
- b. Will anyone be living with you in the future who is not listed above?  
 Yes       No

**6. Vulnerability:**

➤ Do you or a member of your household have, or has had a healthcare provider ever told you/them that they have, any of the following medical problems? Please indicate how many members of your household are affected and who.

<i>Medical issue</i>	<i>Check as appropriate</i>	<i># of household members affected and who</i>	FOR OFFICE USE ONLY
Kidney disease/Renal Disease or Dialysis	<input type="checkbox"/>		
Liver disease, cirrhosis, end-stage liver disease, or HEP C	<input type="checkbox"/>		
Heart disease, arrhythmia, or irregular heartbeat	<input type="checkbox"/>		
HIV+/AIDS	<input type="checkbox"/>		
Emphysema	<input type="checkbox"/>		
Diabetes (ie "sugar problems")	<input type="checkbox"/>		
Asthma	<input type="checkbox"/>		
Cancer	<input type="checkbox"/>		
Stroke	<input type="checkbox"/>		
Tuberculosis	<input type="checkbox"/>		
Epilepsy / Seizure disorder	<input type="checkbox"/>		
Hypertension	<input type="checkbox"/>		
Severe sight or hearing impairment	<input type="checkbox"/>		
Rheumatoid arthritis	<input type="checkbox"/>		
Amputation or physical disability that limits mobility	<input type="checkbox"/>		
History of frostbite, hypothermia or immersion foot	<input type="checkbox"/>		
Swollen, infected, open wounds, or ulcers on the skin	<input type="checkbox"/>		
Difficulty controlling body functions	<input type="checkbox"/>		
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- Check those that apply :
  - I have abused alcohol or have been told that I do
  - I have used or I am currently using drugs
  - I have been in treatment for drugs or alcohol abuse
- Check those that apply:
  - I have been diagnosed with a mental health condition
  - I have received or I am currently receiving treatment for mental health issues
  - I have been taken to hospital against my will
  - A member of my household has been diagnosed with a mental health condition
  - A member of my household has received or is currently receiving treatment for a mental health condition
  - A member of my household has been taken to hospital against their will
- Have you been the victim of physical, emotional or sexual abuse in your life? Y  N
- Have you been the victim of a violent attack since you've become homeless? Y  N
- Are you or your children currently, or have you ever been, victims of domestic violence Y  N
- Have you or your children been the victims of physical, emotional or sexual abuse? Y  N

➤ Please answer the following questions regarding your use of hospital emergency room / inpatient services:

Question (questions with † ‡ apply to families only)	Why?	How Many Times?
- Have you been to the hospital emergency room in the past 3 months?		
- Have you been an inpatient in the hospital in the past year?		
† ‡ - Has a member of your household been to the hospital emergency room in the past three months?		
† ‡ - Has a member of your household been an inpatient in the hospital in the past year?		

➤ What kind of health insurance do you have, if any? \_\_\_\_\_

➤ Child Wellbeing:

- Do any of your children have behavioral issues so severe that they threaten your housing stability? Y  N
- Did any of your children miss more than 25 days of school over the last 12 months? Y  N

➤ Are you currently working on reunification with children that have been removed from your custody? Y  N

➤ Has there ever been a substantiated investigation of abuse or neglect conducted by the Child and Family Services Agency (CFSA) involving you or any member of your household? Y  N

➤ Have any of your children ever been removed from your custody by CFSA? Y  N

7. **HOMLESSNESS**

- In What city and state did you FIRST become homeless?

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City	State
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- Where did you stay last night?

- Emergency Shelter, include motel voucher  Hospital  Transitional housing for the homeless
- Permanent housing for the homeless  Don't Know  Jail, prison, detention facility
- Psychiatric facility  Substance Abuse treatment facility
- Rented room, apartment, or house
- Owned apartment or house  Self paid motel/hotel  Stayed with family or friends
- Place not meant for habitation (car, street, abandoned building)  Refused
- Other; please explain: \_\_\_\_\_

- If you stayed at a hospital, jail/prison, or treatment facility where did you stay prior to that?

- I did not stay at a hospital, jail/prison, or treatment facility
- Emergency Shelter, include motel voucher  Hospital  Transitional housing for the homeless
- Permanent housing for the homeless  Don't Know  Jail, prison, detention facility
- Psychiatric facility  Substance Abuse treatment facility
- Rented room, apartment, or house
- Owned apartment or house  self paid motel/hotel  Stayed with family or friends
- Place not meant for habitation (car, street, abandoned building)
- Refused
- Other; please explain: \_\_\_\_\_

- How long have you currently been homeless? \_\_\_\_\_

- Can you provide third party documentation of homelessness? Example: Letter from a shelter  
 Yes  No

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- **Please explain your situation and needs for housing (are you looking for temporary help or permanent help). \*be descriptive, if you ask for permanent housing you will not be considered for emergency assistance and vice versa. If this section is left blank you will be placed on the bottom of the list.**

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**8. ELIGIBILITY SCREENING WHEN YOUR NAME REACHES THE TOP OF THE LIST.**

The application for Emergency Assistance and Rental Assistance will be reviewed for income eligibility only at this time. Please be advised that when you are notified by Phoenix Health Programs that your name has reached the top of the Waiting List, you will be required to certify and verify household information. Once you have been called for an appointment the following information will be needed:

- Income verification (paystubs, award letter, or zero income documentation).
- Proof of residency (lease or a piece a mail with current address)
- Lease
- Verification of need (letter from landlord, utility bill, or homeless documentation).
- Documentation of a qualifying disability (if required; you will be notified if this documentation is required).
- Landlords contact information (if not on the lease; business card).
- W9 (for the person payment is to be made out to).

**9. APPLICANT CERTIFICATION:**

I/We certify that all information contained in this application for housing assistance is true, accurate and complete to the best of my/our knowledge and belief. I/We understand that misrepresentation of any information will disqualify this application.

Signature of Head of Household \_\_\_\_\_

Date \_\_\_\_\_

Signature of Spouse/Other Adult \_\_\_\_\_

Date \_\_\_\_\_

Signature of Staff \_\_\_\_\_ Date \_\_\_\_\_

**REMEMBER TO ATTACH COPIES OF EACH HOUSEHOLD MEMBERS SOCIAL SECURITY CARD AND DRIVERS LICENSE**

<b><u>FOR OFFICE USE ONLY</u></b>	
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